TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Juan Capello, M.D.

Respondent Name
Great Midwest Insurance Company

MFDR Tracking Number
M4-16-2688-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 6, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "MMI = $350.00
IR – W/ROM = $300.00
TTL = $650.00"

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Division Note: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged as received on May 16, 2016. 28 Texas Administrative Code §133.307(d)(1) requires that:

> The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

The insurance carrier did not submit a response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 22, 2015	Required Medical Examination to Determine Maximum Medical Improvement & Impairment Rating	$150.00	$150.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - RC 01 – The charge for the procedure exceeds the amount listed in the fee schedule.
   - RC 28 – The reduction was made for reasons indicated in note below or on the attached not or letter.
   - RC @G – No additional reimbursement allowed after review of appeal/reconsideration.
   - TX 16 – Claim/service lacks information which is needed for adjudication.
   - TX P14 – The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day.

Issues

1. Are the insurance carrier's reasons for reduction of payment supported?
2. What is the maximum allowable reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code TX 16 – "Claim/service lacks information which is needed for adjudication." Review of the submitted information does not find required information missing from the billing or the report. The insurance carrier's reduction for this reason is not supported.

   The insurance carrier denied disputed services with claim adjustment reason code TX P14 – "The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day." Review of the submitted documentation does not find another procedure performed on the same day which would include the disputed services. The insurance carrier's reduction for this reason is not supported.

2. Per 28 Texas Administrative Code §134.204(j)(3), "The following applies for billing and reimbursement of an MMI evaluation… (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation supports that the requestor performed an evaluation of Maximum Medical Improvement. Therefore, the correct MAR for this examination is $350.00.

   Per 28 Texas Administrative Code §134.204(j)(4), "The following applies for billing and reimbursement of an IR evaluation. … (C)(ii) The MAR for musculoskeletal body areas shall be as follows. … (II) If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area." The submitted documentation supports that the requestor provided an impairment rating, which included a musculoskeletal body part, and performed a full physical evaluation with range of motion of the lower extremities. Therefore, the correct MAR for this examination is $300.00.

3. The total MAR for the disputed services is $650.00. The insurance carrier paid $500.00. An additional reimbursement of $150.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $150.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	July 28, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.